Patient Name:

Date of Birth:

Well Child Check: 3 year visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here? No Yes
Has your child had any reactions to vaccinations in the past? No Yes

Development: Does your child (check all that apply) –

_ kick a ball? _ jump off the ground? _ pedal a tricycle? _ know their name, age, gender?
_ use alternating feet when walking up stairs? _ start to say the ABCs? _ draw a circle?
_ understand concepts like cold, tired, hungry? _ identify several colors?
_ speak and be 75% understandable even to a stranger? _ help with dressing and brushing teeth?
_ speak in 3 word sentences? _ use plurals (cars) _ stay dry all day?

Do you and your child read together daily? Yes No
Who provides daytime care for your child? ______________________________

Nutrition/Elimination/Physical Activity:

What type of milk does your child drink? ____________ How much per day? ______ cups
How much yogurt per day? ____________ How much cheese per day? ____________
What dietary restrictions does your child have, if any? ______________________
Is your child eating 4 servings per day of a variety of fruits and vegetables? Yes No
Does your child eat iron-rich foods (meat, iron-fortified cereal, or beans)? Yes No
How much juice or sweet beverages does your child drink in a day? ______ oz
Does your child eat junk/fast food more than twice per week? No Yes
Are there any problems with pooping or peeing? No Yes
Does your child play actively most days of the week? Yes No
Your child's medications/vitamins/supplements: ______________________________

Dental Health:

Does your child see a dentist every 6 months? Yes No
Does your child (with your help) brush his/her teeth daily? Yes No

Sleep:

How long does your child sleep at night? ____ hours
How long does your child nap? ____ hours

Staying Healthy/Safety:

Does your child get screen time more than 1 hour per day? No Yes
Does your home have a working smoke detector? Yes No
Is your water temperature set to less than 120 degrees? Yes No N/A
Is your child always supervised when near water, including the bathtub? Yes No
Do you have safety guards on upper floor windows and gates for the stairs? Yes No N/A
Does your home have cleaning supplies/medicines/matches locked away? Yes No
Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes No
Does your child use sun protection when outdoors? Yes No
Is your car seat appropriately sized and in the back seat? Yes No
Do you always check for children before backing your car out? Yes No

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Does your child wear a helmet when riding anything with wheels?	Yes	No	N/A
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your baby spend time with anyone who smokes or vapes?	No	Yes	

Please list any new major family medical issues:

____

Who lives in the home with your child?

____

What international travel has your child had since their last well check? (where and how long)

____

What plans are there for international travel with your child in the next 12 months? (where and how long)

____

What concerns would you like to discuss today?

____